STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155159	A. BUILDING	00	01/17/2013
VALUE OF THE OWNER OF GRAPH WE			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIE			CLINTON ST	
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	_
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000					
		for the Recertification ensure Survey.	F0000		
	Survey dates: 16, 17, 2013	January 10, 11, 14, 15,			
	Facility number Provider number AIM: 1002661	per: 155159			
	1/16, 1/17, 20 <sup>-1</sup>	I, N RN (1/10, 1/14, 1/15, 13) RN (1/11, 2013)			
	SNF/NF: 67 Total: 67	<b>,</b>			
	Census Payor Medicare: 3 Medicaid: 60 Other: 4 Total: 67	type:			
		ncies reflect state a accordance with 410			
	Quality review	completed on January			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1DLO11

Facility ID:

000079

TITLE

If continuation sheet

PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155159	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY  COMPLETED  01/17/2013
NAME OF PROVIDER OR SUPPLIER SUMMIT CITY NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZI 2940 N CLINTON ST FORT WAYNE, IN 46805	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH TAG DEFICIENCY.	N SHOULD BE COMPLETION
24, 2013 by Randy Fry RN.		

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Event ID: 1DLO11

Facility ID: 000079

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155159	B. WIN		<del></del>	01/17/	2013
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION			WAYNE, IN 46805		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		<u> </u>	-	TAG	BLI ICILIACT)		DATE
F0223	483.13(b), 483.13	USE/INVOLUNTARY					
SS=A	SECLUSION	USE/INVOLUNTAR I					
		the right to be free from					
		nysical, and mental abuse,					
	·	ent, and involuntary					
	seclusion.	•					
		not use verbal, mental,					
		al abuse, corporal					
	-	voluntary seclusion.	E03	22	The constitution and submissions		02/07/2012
		view and record review	F02	23	The creation and submission of this Plan of Correctiondoes no		02/06/2013
	•	d to ensure 1 resident			constitute an admission by this		
		abuse in a sample of 3			provider of any conclusion set		
	residents revie	wed for abuse			forthin the statement of		
	(resident #48).				deficiencies, or of any violation	າ of	
					regulation.		
	Findings includ	le:					
	_				Thisprovider respectfully requests the the 2567 Plan of Correction be	at	
	On 1/11/13 at <sup>-</sup>	11:13 A.M. an interview			consideredthe Letter of Credible		
		I with Resident #48.			Allegation. This provider requests d		
		dicated staff had been			review in lieu of a post survey follow visit	-up	
		ouple of days ago.			F 223 FREE FROM		
		ndicated she had			ABUSE/INVOLUNTARY		
					SECLUSION		
	•	cident to the facility			Itis the practice of this provide	r <b>to</b>	
	staff.				ensure that residents are free		
					from verbal,mental, sexual, or		
		11:00 a.m. a Resident			physical abuse, corporal punishment, or involuntary		
		ance Form was			seclusion.		
		e Director Nursing					
	Service (DNS)	dated 1/9/13 indicated			What corrective action(s)will	be	
	Resident #48 h	nad her call light on for			accomplished for those		
	over a 1/2 hour	and the resident was			residents found to have beer	1	
	yelling because	e she needed to use			affected by thedeficient		
		Vhen LPN #4 entered			practice		
	•	oom the resident					
		#4 had a rude attitude			• Resident#48 has been		
	I III III III III III III III III III	man a rude attitude			reviewed to ensure the resider	II IS	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155159	B. WING			01/17/2013	3
NAME OF P	ROVIDER OR SUPPLIER		ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
					CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION	FC	ORT W	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
		e remarks toward the			free from any abuse orinvolunged	tary	
	resident. The l				• In-servicewas conduct	her	
		ance Form indicated			by the DNS or designee on the		
	LPN #4 was im	nmediately suspended			facility's abuse policy and		
	and an investig	gation was initiated and			procedureby February 6 th, 2		
	•	vas substantiated and					
	indicated the L	PN #4 was			How will you identify		
	"inconsiderat	e treatment by (sic)			otherresidents having the		
	nurse (sic) four	nd"			potential to be affected by th same deficient practiceand	E	
					what corrective action will be	,	
	On 1/17/13 at	1:00 p.m. a Record Of			taken		
	Facility Inservi	ce was received from					
	the DNS and ir	ndicated on 12/4/12			• Residents residing in t	he	
	LPN #4 had be	en inserviced on the			facility have thepotential to be		
	abuse protocol				affected by the alleged deficie	nt	
	·				practice  •••••conduct	od	
	3.1-27(b)				by the DNS or designee on the		
	( )				facility's abuse policy and		
					procedureby February 6 th , 2	013	
					What measures will be puting		
					place or what systemic		
					changes you will make to		
					ensure that the		
					deficientpractice does not		
					recur		
					•	ed	
					by the DNS or designee on the		
					facility's abuse policy and		
					procedureby February 6 th , 2	013	
					How the corrective action(s)	will	
					be monitored to ensure the		
					deficient practice will not rec	ur,	
					i.e., whatquality assurance		
					program will be put into plac	e	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155159		A. BUILDING	00	COMPLETED				
		155159	B. WING		01/17/2013			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
SUMMIT	CITY NURSING AN	ND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE			
	•			(EACH CORRECTIVE ACTION SHOULD BE	DATE  DOCOI  daily and sure of  riew d of on ure			

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Event ID: 1DLO11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	, print paric	00	COMPLETED
		155159	A. BUILDING		01/17/2013
		100100	B. WING		01/11/2010
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
TVI WILL OF T	KO VIDEK OK BOI I EIEK		2940 N	I CLINTON ST	
SUMMIT	CITY NURSING AN	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0356	483.30(e)				
SS=C	POSTED NURSE	STAFFING			
00-0	INFORMATION	2017111110			
	The facility must	nost the following			
	information on a				
		daily basis.			
	<ul><li>o Facility name.</li><li>o The current dat</li></ul>	•			
		er and the actual hours	1		
		lowing categories of			
		censed nursing staff directly			
		sident care per shift:			
	- Registered r				
		actical nurses or licensed			
		s (as defined under State			
	law).				
	<ul> <li>Certified nur</li> </ul>				
	o Resident censu	IS.			
	The facility must i	post the nurse staffing data			
		on a daily basis at the			
	•	n shift. Data must be			
	posted as follows				
	•				
	o Clear and reada				
	·	place readily accessible to			
	residents and visi	itors.			
	The facility must	upon oral or written			
	•	rse staffing data available			
	•	eview at a cost not to			
	exceed the comm				
	CACCCO LITE COITIII	idility standard.			
	The facility must i	maintain the posted daily			
		a for a minimum of 18			
	•	luired by State law,			
	whichever is grea				
	_	ervation and interview	F0356	The greation and submission of	of 02/06/2013
			1.0330	The creation and submission of this Plan of Correctiondoes no	
	•	d to ensure nurse staff			•
	posting was co	mpleted on a daily		constitute an admission by this	
	basis	-	1	provider of any conclusion set	
	230.0			forthin the statement of	
				deficiencies, or of any violation	n of
	Findings includ	ie:		regulation.	

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PRINTED: 02/06/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155159	A. BUILDING  B. WING	(X3) DATE  COMPI  01/17	LETED
SUMMIT (X4) ID PREFIX	PROVIDER OR SUPPLIER  CITY NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, 3 2940 N CLINTON ST FORT WAYNE, IN 46  ID PROVIDED PREFIX (EACH CORREC CROSS-REFERE	R'S PLAN OF CORRECTION CTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	(X5) COMPLETION
TAG	Based on observation and interview, During initial tour of the facility, at 10:05 a.m., on 1/10/13, the nursing staffing schedule sheet was posted inside the window of the front entrance reception desk. The staffing schedule was dated 12/20/12. The Director of Nursing Services was interviewed at 10:10 a.m., on 1/10/13, and indicated the staffing schedule should be changed daily, but the facility hired a new scheduler and the Director of Nursing Services indicated she was not sure the new scheduler was aware she had to post the schedule daily.	Thisprovider that the 256 be considered Credible Aller requests despost survey F 356 Poste information It is the praction ensure that following information basis: Facility date, the total actual hours following catal and unlicens directly respondicensed voc (as defined to Resident cerval accomplish residents for affected by practice  What correct accomplish residents for affected by practice  More identified to alleged deficion. The scheduled is the will you other reside potential to same deficients.	ormation on a daily ty name, The current al numberand the s worked by the tegories of licensed ed nursing staff consible for resident ff:Registered nurses, actical nurses or cational nurses under state law) and nsus ctive action(s)will be ted for those bund to have been thedeficient  esidents were be affected by the cient practice nursingstaffing s now posted daily	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPLETED
155159			B. WING			01/17/2013
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
CLINANAIT					CLINTON ST	
		ND REHABILITATION			VAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	-	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG	REGULATORT OR	ESCIDENTIF FING INFORMATION)		IAG	taken	DATE
					tunon	
					Residents residing in the facility have thepotential to be affected by the alleged deficient practice The nursing staffing schedule is posted daily In-servicewill be provide to the DNS by the Executive Director or designee on assuringthe required staffing posting is completed on a daily basis by February 6 th ,2013  What measures will be puting place or what systemic changes you will make to ensure that the deficient practice does not recur  In-servicewill be provided to the DNS by the Executive Director or designee on assuring the required staffing	nt ded y to ded
					posting is completed on a daily basis by February 6 th ,2013 • ED/designeewill ensur staffing is posted at the beginn of the day	re
					How the corrective action(s)	will
					be monitored to ensure the	
					deficient practice will not rec i.e., whatquality assurance	ur,
					program will be put into place	e
					• A "Staffing posting aud tool" will be completed daily x weeks, weekly x 2 weeks,	· · · · · · · · · · · · · · · · · · ·

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155159	B. WING		01/17/2013
NAME OF P	PROVIDER OR SUPPLIEF	· }		ADDRESS, CITY, STATE, ZIP CODE	-
				I CLINTON ST	
SUMMIT	CITY NURSING AI	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)	TAG		5.112
				andthen monthly thereafter to assure compliance is met threshold of 100%	
				• The CQI team will rev	iew
				the datacollected. If threshold	
				100% is not achieved, an action	
				plan willbe developed, to ensu compliance	ıre
					41-
				Compliance date: February6 2013	tn ,

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159		ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP CODE  I CLINTON ST	(X3) DATE SURVEY COMPLETED 01/17/2013
SUMMIT	CITY NURSING AN	ND REHABILITATION		WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=D	PROCEDURES, The facility must emergency drugs residents, or obta agreement descri part. The facility personnel to adm permits, but only supervision of a li  A facility must pro services (includin the accurate acqu dispensing, and a and biologicals) to resident.  The facility must services of a licer provides consulta provision of pharm  Based on obse the facility faile was administer manufacturers four residents r medications (#  Findings included  During observation pass, at 4:00 p #2 prepared m	provide routine and and biologicals to its in them under an ibed in §483.75(h) of this may permit unlicensed inister drugs if State law under the general idensed nurse.  Divide pharmaceutical g procedures that assure ulring, receiving, administering of all drugs of meet the needs of each employ or obtain the need pharmacist who ution on all aspects of the macy services in the facility.  Privation and interview, d to ensure medication red following the instructions for one of reviewed for G-tube \$498).  The service of the medication and interview are instructions for one of reviewed for G-tube \$498).  The service of the medication and interview are instructions for one of reviewed for G-tube \$498).	F0425	The creation and submission of this Plan of Correctiondoe not constitute an admission by this provide of any	<b>!</b> S

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155159		A. BUILDI B. WING	ING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/17/2013	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  CLINTON ST	
SUMMIT	CITY NURSING AN	ND REHABILITATION		FORT V	VAYNE, IN 46805	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		za capsule (used to			conclusion se	t
		iopathic constipation)				
	•	e capsule in a plastic			forthin the	
		cup, and then gave			statement of	
	the medication	•			deficiencies, d	or
	,	ube (G-tube). The LPN and talked to the			of any violation	
		e Practitioner about			_	<b>'</b> "
		sule through the G-tube			of regulation.	
		d she was worried he crushed capsule in			Thisprovider	
		it the physician did not			respectfully	
		dication and the LPN			•	
		i-tube had not clogged			requests that	
	•	ndicated it was difficult sule through the			the 2567 Plan	
		e was observed to use			of Correction	
	•	ad to add water several			_	
		edication cup in order			be	
	_	cation through the psule was sticking to			consideredthe	•
		plastic medication cup.			Letter of	
	I DN #2 was in	terviewed, at 9:40				
		3. When asked			Credible	
	·	idministration of the			Allegation.	
	_	n the G-tube, she was			Thisprovider	
		e Internet to look up . She indicated			-	,
		e information on the			requests desk	<b>L</b>
		nitiza capsule should			review	
	not be crushed				in lieu of a pos	st
	An interview w	th the Assistant				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155159		X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  X3) DATE S  COMPLE 01/17/2		TED			
NAMEOU	DROVIDED OF GUIDA 152	<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				CLINTON ST			
SUMMIT	CITY NURSING AI	ND REHABILITATION		FORT \	WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	<b>.</b>	rsing (ADN) on 1/15/13					
		dicated the facility no			survey		
		ug handbooks for			follow-up visit	f I	
	_	ormation, instead they			_		
	use the Interne	et. The ADN indicated			F 425		
	no specific site	is used for stead they type the			Pharmaceutic	al	
		edication in "Google"			services-accu	ır İ	
		utable web site for			<u>_</u>		
	information.				ate procedure		
	A : t	:41- 411			Itis the practice of this provide ensure that pharmaceutical	er to	
		ith the pharmacist on			services(including procedures	,	
		A.M. indicated in the			that assure the accurate		
		es there was such a			acquiring, receiving, dispensin	•	
		y of drug, as it was in			and administering of all drugs	and	
	_	at you would not even			biological) to meet the needs ofeach resident <b>What</b>		
		ation, and indicated it			corrective action(s)will be		
		spec of dust. He			accomplished for those		
		mitiza should not be			residents found to have bee	n	
		hould not be given			affected by thedeficient		
	_	h a G-tube. The			practice · Resident#98	-41	
	l •	icated, "We probably			medication review was completely by pharmacy to assure	eted	
		t them know, it should			compliance · Resident#98 is		
	not be given th	rough a g-tube".			receiving medication per		
	Am intervious	:4b DN #5 at 0:45 a m			physician's order · In-service	was	
		ith RN #5 at 9:45 a.m.,			completed by the DNS or		
		dicated the physician			designee on ensuring g-tube medications areadministered		
		ew order regarding the			following the manufacturer's		
		dicated the physician			instructions by February 6 th		
		dication to be given			,2013. How will you identify	,	
	_	tube because he had			otherresidents having the		
		dications on this			potential to be affected by the	ne	
		e Amitiza was the only			same deficient practiceand what corrective action will b		
	medication tha	t worked.			taken · Residents residing in		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DINI DING	00	COMPLETED
		155159	A. BUILDING	<del></del> -	01/17/2013
			B. WING	ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
			I CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION	FORT	WAYNE, IN 46805	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Review of the	physician order,		facility thatreceive medication	•
	provided by RI	N #5, and dated		G-tube have the potential to b	
		ited to continue Amitiza		affected by the allegeddeficier	
	1	he contents into water		practice · All residents residin	g in
	•			the facility thatreceive	
	and administer	r via the G-Tube.		medications per g-tube will	
	2.4.25(5)(4)			receive pharmacy medication	ltant
	3.1-25(a)(1)			review by thepharmacy consuto assure medications are	illaill
				administered per	
				manufacturer'sguidelines and	
				physician orders by February	6 th
				, 2013 · In-servicewas comple	
				by the DNS or designee on	
				ensuring g-tube medications	
				areadministered following the	
				manufacturer's instructions by	'
				February 6 th ,2013. What	
				measures will be putinto pla	
				or what systemic changes ye	ou
				will make to ensure that the	
				deficientpractice does not	
				recur · In-servicewas comple	eted
				by the DNS or designee on	
				ensuring g-tube medications	
				areadministered following the manufacturer's instructions ar	nd
				physician orders byFebruary 6	
				2013. · Facility'spharmacy	, ui,
				consultant will review resident	s
				receiving medication per	
				g-tubemedication regimen	
				monthly to assure medication	is
				administered following	
				manufacturer'sinstructions an	d
				physician orders How the	
				corrective action(s)will be	
				monitored to ensure the	
				deficient practice will not red	cur,
				i.e., whatquality assurance	
				program will be put into place	
	I		- 1	A "G-tube medication regime     I → A "G-tube medication	en l

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155159	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/17/2013
	ROVIDER OR SUPPLIEF	L  ND REHABILITATION	STREET . 2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	IAG	administrationtool" will be completed weekly x 4wee monthly x 2 months, and the quarterly thereafter to assecompliance is met threshout 100%. The CQI team will the datacollected. If threshout 100% is not achieved, an aplan willbe developed, to ecompliance Compliance February6 th, 2013.	ks, nen ure Id of review nold of action ensure
			1	1	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
		155159	B. WIN			01/17/	2013
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1					
OL IN AN ALT		UD DELLA DIL ITATIONI			CLINTON ST		
SUMMIT	CITY NURSING A	ND REHABILITATION		FORTV	VAYNE, IN 46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=D	INFECTION CON	ITROL, PREVENT					
	SPREAD, LINEN	S					
	The facility must	establish and maintain an					
	Infection Control	Program designed to					
	provide a safe, sa	anitary and comfortable					
	environment and	to help prevent the					
	development and	transmission of disease					
	and infection.						
	(a) Infection Cont						
	•	establish an Infection					
	Control Program						
	` '	controls, and prevents					
	infections in the fa						
	` '	procedures, such as					
		be applied to an individual					
	resident; and	sound of incidents and					
	` '	ecord of incidents and srelated to infections.					
	corrective actions	related to infections.					
	(b) Preventing Sp	oread of Infection					
		ection Control Program					
	` '	resident needs isolation to					
		ad of infection, the facility					
	must isolate the r						
		ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or					
		t contact will transmit the					
	disease.						
	(3) The facility mu	ust require staff to wash					
	their hands after	each direct resident contact					
	for which hand wa	ashing is indicated by					
	accepted profess	ional practice.					
	(c) Linens						
		nandle, store, process and					
	•	o as to prevent the spread					
	of infection.						
		ervation, interview, and	F04	41	The creation and submission of		02/06/2013
	record review,	the facility failed to			this Plan of Correctiondoes no	t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLETED
		155159	A. BUI B. WIN			01/17/2013
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF PROVIDER OR SUPPLIER				CLINTON ST		
SUMMIT CITY NURSING AND REHABILITATION			FORT WAYNE, IN 46805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ary procedure was			constitute an admission by this provider of any conclusion set	
		iving medications			forthin the statement of	'
	_	ll tubes. This affected			deficiencies, or of any violation	n of
	3 of 4 resident	s observed receiving			regulation.	
	medication thre	ough their feeding				
	tubes, Resider	nts # 97, 98, and 101.			Thisprovider respectfully requi	
					that the 2567 Plan of Correction be considered the Letter of	on
	Findings include	de:			Credible Allegation. Thisprovi	ider
	_				requests desk review in lieu of	
	During observa	ation of the medication			post survey follow-up visit	
	_	o.m., on 1/14/13, LPN			F 441 Infection	_
	#2 was observ				F 44 i iiileciloi	<u> </u>
		r Resident #101. The			control,	
		bserved to have a			Control,	
		e feeding infusing, the			prevent sprea	d,
		ne tube feeding,			<del>-</del>	
	•	eeding tube from the			linens	
		and without covering			Itis the practice of this provide	
	_	feeding tube, hung it			ensure that an infection contro	
		where the tube feeding			program isdesigned to provide safe, sanitary and comfortable	
	was hanging.	viiere the tabe recaing			environment and to helppreve	
		the medications			the development and	
	_				transmission of disease and	
	_	eg tube, then replaced			infection	
		tube into the Peg tube				
	site.				What corrective action(s)will	be
		4/44/40   55: "5			accomplished for those residents found to have been	,
	•	on 1/14/13, LPN #2			affected by thedeficient	'
		preparing medications			practice	
		98. After preparing the				
	-	he removed the			Resident#101 g-tube	
	•	om the G-tube site,			medication administration was	
	then laid the tu	ibe on the blanket on			reviewed to assure prevention	
	the resident's I	ap, without covering			ofinfection program is in place	
	the end of the	feeding tube. The tube			during medication administrati	on
		lide down between the			• Resident#98 g-tube	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	LETED
		155159	B. WING		01/17	7/2013
NAME OF F	DOMDED OF CHIRD IE	)	_	EET ADDRESS, CITY, STATE, ZIP CO	DE	
NAME OF F	PROVIDER OR SUPPLIEF	(	294	10 N CLINTON ST		
		ND REHABILITATION		RT WAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE AP		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	,		DATE
		e side of the arm of the		medication administration reviewed to assure previous		
		resident was sitting in.		ofinfection program is in		
		the tube was exposed,		during medication admir		
	•	tube was not visible.		• Resident#97 g-t		
		e finished giving the		medication administration	on g-tube	
		he pulled the feeding		was reviewed to assure	•	
	· ·	nd the end of the		preventionof infection pr	•	
	uncovered tube	e was noted to touch		in place during medicati administration	UH	
	the resident's h	nand		• In-service will be	provided	
				to all licensed nursing p	•	
	At 4:35 p.m., o	n 1/14/13, LPN #2 was		by the DNS or designee		
	•	aring medications for		facility's infection contro	l program	
		The resident was		regarding g-tube		
		a continuous tube		medicationadministratio	n by	
		g, and the LPN paused		February 6 th , 2013  • • • • Skillsvalidation v	will bo	
	_	moved the feeding		provided to all licensed		
	_	G-tube site and laid the		personnel by the DNS of	-	
	•	ver a pillow which was		on assurance of the fac		
	_			infection control prograr	n	
		prop the resident's		regardingg-tube medica		
		I of the uncovered tube		administration by Febru	ary 6 th ,	
		e touching the linen on		2013		
	the resident's t	pea.				
				How will you identify		
	The Infection C			otherresidents having	the	
	•	Nurse was interviewed		potential to be affected	-	
	at 4:20 p.m., o			same deficient practice		
		ad just given an		what corrective action	will be	
	inservice on er	nteral feedings, and		taken		
	indicated it wo	uld be appropriate to		Desidente no de	na in the	
	place the feedi	ng tube in a bag		Residents residents residents residents residents residents residents.		
	hanging on the	e feeding tube pole, but		administration per g-tub		
		ppropriate to lay the		the potential to be affect		
		e on a resident's bed,		alleged deficient practic	-	
		covered tube over the		•		
	feeding tube p			to all licensed nursing p		
	l recarring tube p	010.				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		155159	B. WING	j		01/17/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CLINTON ST		
SUMMIT	CITY NURSING AN	ND REHABILITATION		FORT V	VAYNE, IN 46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	by the DNS or designee onthe	DATE	
	Review of the F Enteral tube-M Administration,				facility's infection control progr regarding g-tube medicationadministration by February 6 th, 2013	am	
	provided by Co	orporate Nurse #1, on			• • • • • Skillsvalidation will be		
	the afternoon o	of 1/15/13, indicated			provided to all licensed nursing	-	
	there were no	specific instructions on			personnel by the DNS ordesig	nee	
	where to place	the feeding tube while			on assurance of the facility's infection control program		
	giving medicati	ons.			regardingg-tube medication		
					administration by February 6 t	h ,	
	Corporate Nurs	se #2 was interviewed,			2013		
	at 10:56 a.m., o	on 1/17/13, and					
	indicated there	was no written			What measures will be puting	ro	
	procedure rega	arding what to do with			place or what systemic		
	the feeding tub	e when disconnected			changes you will make to		
	to give medicat	tions, and indicated the			ensure that the		
	facility policy di	d not address this.			deficientpractice does not		
	She indicated i	deally the end of the			recur		
	feeding tube sh	nould be capped while			•=====ln-servicewill be provide	dod	
	giving medicati	ons, but the procedure			to all licensed nursing personr		
	was a "clean" t	echnique, not a sterile			by the DNS or designee onthe		
	one, and there	was no information on			facility's infection control progr	am	
	the exact proce	edure.			regarding g-tube		
					medicationadministration by February 6 th , 2013		
	3.1-18(b)(4)				• Skillsvalidation will be		
					provided to all licensed nursing	g	
					personnel by the DNS ordesig	nee	
					on assurance of the facility's		
					infection control program regardingg-tube medication		
					administration by February 6 t	h,	
					2013		
					• DNS/designeewill		
					conduct rounds on all three sh	ifts	
					to ensure proper infection		
					controltechnique per utilized		

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		IDENTIFICATION NUMBER:  155159	A. BUILDING  B. WING	00	COMPLETED 01/17/2013
	ROVIDER OR SUPPLIER	ND REHABILITATION	2940 N	ADDRESS, CITY, STATE, ZIP CODE CLINTON ST NAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	will  will  sur,  e  II  sure  f  ew  of  on  ire

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Event ID: 1DLO11

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